APPEAL REQUEST FORM AND INSTRUCTIONS

Members who wish to file a formal appeal related to an adverse claim determination must complete the Surency Flex Appeal Request Form. This form should only be used to submit an appeal.

The Appeal Request Form must be received by Surency Flex within 180 days from the date of the original adverse claim determination or the corresponding remittance advice.

After receiving this Appeal Request, Surency Flex will either send you a written decision regarding your appeal or, if necessary, request additional information regarding your appeal within 20 business days of receipt. However, when special circumstances arise, Surency Flex may require additional time to reach a final decision.

- To submit an appeal, complete the form in its entirety and attach all documents, records and any other information related to the appeal.

- Check all documents you submit with your appeal in the appeal information section of the form and provide the reason you disagree with the claim determination.

- Return completed form and all documentation to:

Fax Number:	316-272-4841
Email:	flex@surency.com
Mailing Address:	Surency Flex ATTN: APPEALS PO Box 789773 Wichita, KS 67278-9773

If your first appeal is denied, you may have the right to submit a second level appeal with your plan administrator, usually your employer. If you are eligible to submit a second level appeal, you should submit your second level appeal within 180 days of the date you received the first appeal denial. If you do not make that second level appeal within 180 days of that date, you may lose your right to appeal your adverse benefit determination or forfeit your right to file a lawsuit in court or both.

Your second level appeal submission should include: additional documents and any other information that may support your appeal. Your plan administrator will review your second level appeal and additional information independently of your first appeal. Your plan administrator will decide your second level appeal within 60 days after the date they receive your second level appeal.

Surency FLEX

APPEAL REQUEST FORM

Member Information

Member Name (Please Print) _____

Date of Birth (mm/dd/yyyy) _____

Company _____

Member ID or SS # _____

Address _____

City _____

State _____

ZIP Code _____

Email Address* _____

***Email Address is required. Surency will send your appeal response to this email address.**

Appeal Information

Claim Number _____

☐ 1st Appeal ☐ 2nd Appeal

Please attach supporting documentation and mark what is attached.

☐ Itemized Receipt ☐ Explanation of Benefits (EOB) ☐ Letter of Medical Necessity

☐ Prescription ☐ Other _____

Please provide the reason you disagree with the claim determination. Attach additional information if necessary.

Member Signature _____

Date _____

Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773

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